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documentation requirements that will have a significant impact on the work of your CDI team. The higher degree of specificity of information needed to code accurately will have a direct correlation to reimbursement and compliance. CDI specialists need a firm understanding of the new code set and the rules that govern it to obtain the appropriate level of documentation from physicians. The Clinical Documentation Improvement Specialist's Guide to ICD 10 is the only book that addresses ICD 10 from the CDI point of view. Written by CDI experts, it explains the new documentation requirements and clinical indicators of commonly reported diagnoses and the codes associated with those conditions. You'll find the specific documentation requirements to appropriately code conditions such as heart failure, sepsis, and COPD. Learn from your peers. The Clinical Documentation Improvement Specialist's Guide to ICD 10 includes case studies from two hospitals that have already begun ICD 10 training so you can use their timelines as a blue print to begin your organization's training and implementation. ICD 10 implementation happens in 2013. It's not too soon to start developing the expertise and comfort level you'll need to manage this important industry change and help your organization make a smooth transition. Benefits Tailored exclusively for CDI specialists. Side by side comparison of what documentation is necessary now v what will be required starting October 1, 2013. Timelines to train physicians in new documentation requirements to ensure readiness by implementation date. Strategies and best practices to ensure physician buy in.

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